California Health Policy and Data Advisory Commission
1600 Ninth Street, Room 432
Sacramento, California 95814
(916) 654-1817
FAX (916) 654-1832
www.chpdac@oshpd.ca.gov

Approved Minutes
California Health Policy and Data Advisory Commission
April 11, 2005

The meeting was called to order at 10:11 a.m. by Chairman Dr. William S. Weil at the Hyatt Regency at Capitol Park, Sacramento, California.

Commissioners
Present:
William S. Weil, MD, Chairperson
William Brien, MD
Marjorie Fine, MD
Janet Greenfield, RN
Howard L. Harris, PhD
Paula Hertel, MSW
Hugo Morris
Jerry Royer, MD, MBA
Corinne Sanchez, Esq.

Absent:
M. Bishop Bastien
Sol Lizerbram. DO
Kenneth M. Tiratira, MPA

Staff Present:

CHPDAC: Jacquelyn Paige, Executive Secretary (Director); and Rebecca Markowich, Executive Assistant

OSHPD: David Carlisle, MD, PhD, Director, OSHPD; Michael Kassis, Deputy Director, Healthcare Information Division; Kenny Kwong, Accounting and Reporting Section; Jonathan Teague, Health Information Resource Center; Candace Diamond, Patient Discharge Data Section; Joseph Parker, PhD, Healthcare Quality and Analysis Division

Also in Attendance: Vito Genna, Chair, Health Data and Public Information Committee; Sarah Minden-Weil, MSW, Los Angeles County Department of Mental Health

Chairman's Report: Dr. Weil reported that the terms of several Commissioners have expired. Members should continue coming to meetings until the reporting authorities make new appointments.

The Commission recently has not met on a regular basis due to the uncertainty of the Commission being sunsetted. The report submitted to the Little Hoover Commission by the Administration proposed sunsetting 88 boards and commissions, but was later rescinded after hearings by the Little Hoover Commission.

Executive Secretary's Report: (The California Performance Review is winding down effective May 1.)

Mike Genest, formerly with the Department of Health and the Department of Social Services, has been appointed Undersecretary of the Health and Human Services Agency.

Steve Kessler has been appointed Chief Deputy of the Department of Finance. Mr. Kessler is well versed in the current health and human service delivery system at the State and county levels. Mr. Kessler formerly worked at the Health and Human Services Agency, Department of Health, and Department of Finance.

Bruce McPherson has been sworn in as the new Secretary of State.

A request has been received for an appeals hearing. Since the implementation of MIRCal, there have been no other requests for hearings. The appeal will be heard on Tuesday, April 26, in Sacramento. Corinne Sanchez and Dr. Howard Harris and a third person (to be selected later) will be hearing the appeal.

There was a reminder that the annual Conflict of Economic Interest forms are due. All Commissioners, as well as the Executive Secretary (Director), must file the forms each year and upon resignation from the Commission.

A new program, called CalATERS, will process travel claims electronically, effective in June. Members should continue to fill out the draft travel form and submit receipts to the Commission Office. Commission staff will fill out the travel claims for Commissioners and submit them electronically.

Commissioners whose terms have expired are: Dr. Marjorie Fine and Corinne Sanchez, who were appointed by the Speaker and Senate Rules; Governor appointments include Dr. Weil, Paula Hertel, Howard Harris, and Ken Tiratira. Commissioners who are interested in being reappointed are encouraged to reapply. Bishop Bastien's term expired several years ago and he has not been replaced. Tom McCaffery, who resigned to become Chief Deputy Director of the Department of Health Services, has not been replaced. Mr. Morris requested that a current list of members, dates of appointments and the appointing authority be sent to Commissioners.

Approval of Minutes: It was moved, seconded, and carried that the minutes from the December 13, 2004, meeting be approved.

Director's Report: David M. Carlisle, MD, PhD, Director, OSHPD

There has been a revision in the proposal for the dissolution and absorption of various boards and commissions within the State of California. In addition to CHPDAC, the Rural Health Policy Council was slated for absorption into another department. OSHPD administers this Council, on behalf of the Agency, which coordinates regional and rural outreach activities on behalf of the State of California. The Council will continue to operate for the foreseeable future.

Dr. Carlisle recently toured the Saperstein ICU Center construction at Cedar Sinai Medical Center. There is an unprecedented level of construction currently under review by OSHPD. More revenue for construction fees has been coming into the Office than in previous years. The Facilities Development Division has been able to respond to this increase in workload by hiring 43 of 46 positions authorized in the Governor's Budget last year. The Office is moving toward filling the remaining three positions.

There has been a slight drop off in projects receiving a first review within 60 days from the previous standard. For large construction projects or for a brand new hospital construction project, OSHPD negotiates directly with the institution. On average OSHPD actually accounts for a minority of the total review time needed for approval of projects, with the rest of the time devoted to other activities such as the design team and contractor.

The shortage area designation staff is often asked to consult with other states on behalf of the designation process. California has been quite successful, under the leadership of Pablo Rosales and Konder Chung, in facilitating and expanding the efficiency of the review process. After the 1990 census when OSHPD undertook a statewide review of the designation status, it took over three years. It now takes less than one year because of computerized geographic information systems.

There is a disparity between the general perceptions of the status of emergency rooms in California. ERs in California are overcrowded, and getting worse. ERs inside hospitals are closing, not just because of hospital closures, but many hospitals are closing down ER services and are becoming non-ER-based hospitals. This has impacted ER access in large urban counties, where paramedic ambulances are being diverted from one ER to another.

The percentages of beds devoted to non-urgent visits, those that could be accommodated in another setting, have decreased in the last ten years in California.
The percentage of resources for urgent and critical patients has increased significantly. It is really the patients requiring major intervention that often result in hospitalization, and not the non-urgent, ambulatory patients that are clogging the emergency rooms. There's some consensus that ERs are having difficulty admitting urgent and critical patients to hospitals, and this may be because hospitals are having difficulty opening up beds. Hospitals staff to the level of demand for their services because of difficulties in reduced nursing ability. When there is increased demand, the hospital typically responds by bringing in nurses from the outside via registries or available staff.

Compensating for the overall loss in ERs is an actual increase in the number of total beds that ERs are able to provide in California. In the last ten years in LA County, there was a 21 percent reduction in the number of emergency departments in the county, but the total number of ER beds actually increased by nine percent during the same period. However, there may be a loss of capacity within some of the core urban areas as capacity migrates to more peripheral regions, perhaps resulting in an access issue in urban parts.

Budget: The Assembly Health Committee will hold budget hearings on April 28 and the Senate Health Committee hearing is May 7. OSHPD's budget is fairly intact, except for use of the Data Fund to support the Song-Brown Family Practice Training Program, usually

supported from the General Fund. Last year, Data Funds were diverted to support the Song-Brown program entirely. This year, it is proposed that the program be supported 50 percent from the Data Fund and 50 percent from the General Fund, with no reduction in funding. General Fund monies are limited, and there could be a modification of the proposed funding structure during the budget hearing process.

Legislation: SB 167 (Speier) gives hospitals a choice of adhering to the timeline for implementation of seismic safety, which includes a 2008 structural compliance deadline that can be extended to 2013, or accelerating the 2030 deadline to 2020 and also delaying the structural deadline to 2020.

AB 1316 (Nation and Richman) is very similar to SB 167, but mandates the 2020 deadline. Hospitals would have to accelerate their complete compliance by ten years in exchange for a 12-year deceleration of their structural compliance.

AB 44 (Cohn) is similar to a bill introduced last year that would allow preliminary review by outside reviewers before plans are submitted to OSHPD. The outside reviewers would certify that plans are consistent with building codes and possibly receive an accelerated review process once it reaches OSHPD. This may not necessarily decrease the total review time, but would decrease time within OSHPD.

There are other funding bills that have been introduced calling for fund measures to support seismic safety compliance.

Healthcare Information Division Update: Mike Kassis, Deputy Director, Healthcare Information Division

Status of Special Fee Regulations: The regulation package, upon adoption, would raise the assessment fee paid by hospitals to .034 percent of gross operating expenses, effective July 1. The maximum allowable is .035 percent. The assessment fee was lowered this past fiscal year because the reserve was too high. It was thought that the amount of funds that should be in the fund at any one time should be close to four or five million dollars, allowing for funds to implement new programs such as outcomes work, new publications or new data collection systems, and should not wait a year or two to amass the funding for implementation. After the cut was made, OSHPD was told by the Legislature that the Song-Brown program would be funded from the Data Fund, rather than from the General Fund. As a result, it will now take two or three years to reach the four million dollar reserve before entertaining any new activities. In regard to the Song-Brown program, it is a question of either continuing to use Data Fund or General Fund dollars, or reduce the size of the program.

Commissioner Morris suggested that during the budget process Dr. Carlisle let the Legislature know “Data Funds are sacrosanct and to leave them alone. Question was raised as to what potentially could be cut from the Song-Brown program. Dr. Carlisle responded that personnel could be reduced who support the family practitioner residency program or among the physician assistant and nurse practitioner training programs by reducing funding. The number of positions to support the program may or may not have an impact on the number of family practitioners who are trained in California.

CHA Voluntary Guidelines: In February 2004, the California Healthcare Association issued voluntary charity care guidelines, developed in response to proposed legislation SB 379 (Ortiz) and AB 232 (Chan). These guidelines established a broad range of billing and collection practices that hospitals would follow. If a patient were below 300 percent of the federal poverty level, they would be eligible for charity care. A hospital would have to wait 120 days after billing before beginning formal collection activities. CHA conducted a formal survey this year and will issue a report to the Legislature and the Governor.

Charity Care: SB 24 (Ortiz) and AB 774 (Chan), related to charity care, were introduced this year and are being tracked. Both bills would require hospitals to develop a charity care policy and a reduced payment policy, and would require the policies to be submitted to OSHPD. These bills would increase the waiting time before formal collection activities to 150 or 180 days and would impose a $500 a day penalty for each violation. SB 24 would require the nonprofit hospitals to provide a minimum level of charity care expressed as a charity care cost over their net patient revenue.

Top 25 Procedures: AB 1045 (Frommer) and SB 917 (Speier) would require hospitals to make available a list of their 25 top inpatient procedures and 25 top outpatient procedures, grouped by Medicare Diagnosis Related Group (DRG). Each hospital would be required to provide a written estimate of the expected cost of hospitalization at the time of admission, if requested by the patient. These lists would be submitted to OSHPD, which would compile and publish the information on the website. The author's intent is for OSHPD to create an online query system that would allow a user to look at a diagnosis or a certain type of injury and then find the average charge for that procedure, as submitted by the hospitals.

SB 917 would require OSHPD to compile a list of the top 25 DRGs for each hospital, adjusted for severity of illness in risk mortality, called All Patient Refined (APR) DRGs. Currently, the payer bill of rights gives OSHPD the authority to publish the ten most common DRGs. OSHPD could use the patient level data currently collected and create the top 25 DRGs, at no additional cost to the hospital.

There would be a cost to hospitals to implement AB 1045 because hospitals would compile the lists and submit the information to OSHPD.

Commissioner Morris said he is well acquainted with Assemblyman Frommer and his father, and asked if the Commission could educate Assemblyman Frommer on the full impact of what he has proposed. Ms. Paige said the process is that legislative staff has access to the Administration and they call or meet with the Director, including OSHPD staff, regularly. Legislative staff typically does not meet with boards or commissions, but meets with

program staff. The Office has two roles with regard to legislation. The first is a technical assistance role where the Office works with the authors and answers technical questions. The other role is to advise the Administration on legislation. The Office considers feedback from the Commission when it prepares the legislative analyses.

All of the proposed legislative bills are on the website (leginfo.ca.gov), as well as thier status. There are currently about 3,000 bills before the Legislature.

California Hospital Report Card: AB 1046 (Frommer) "would require OSHPD to develop a California hospital report card by July 1, 2006, to provide healthcare consumers with information about measures of the hospital quality and to develop measures for inclusion in the report card, in consultation with various consumer and stakeholder organizations." It would also allow OSHPD to be able to lift the current limit on the number of data elements that can be added to the patient discharge data system currently limited to 15 over a five-year period.

The author's office is using the Chart One Group as an example of the kinds of measures to be included, such as the National Quality Forum, OSHPD outcome reports, JCAHO measures, and others. This is a wide based group of stakeholders in hospital care that would like to expand upon the types of quality reporting on hospitals done by some of the commercial websites and newspapers. There are about 200 hospitals targeted for participation in this voluntary effort. Dr. Parker of OSHPD has been a non-voting participant on the steering committee. The idea behind the voluntary effort was to survey hospitals to see what data are being reported, to reduce the duplication effort. They are very sensitive to the fact that there are multiple reporting requirements in slightly different formats.

OSHPD outcome reports are risk adjusted, given the severity of illness for the patients treated. OSHPD reports list the hospitals as better than expected, lower than expected, and performing as expected.

Nationwide, there are several other applications of outcome information. Providers use the information to target their quality improvement strategies. Health plans and purchasers use the information to direct patients en masse to specific providers, based on quality and outcomes. The individual patient may not be able to direct a paramedic ambulance to take them to a specific hospital. Only half of the bypass surgeries are elective, and there is not much discretion on where to have the surgery.

Dr. Weil said the HMOs are now developing centers of excellence for such things as heart and brain surgeries, as well as transplants. Patients have no qualms about switching their doctors to obtain one at the most prestigious institutions.

Some members of the Chart One steering committee are interested in this voluntary program moving to OSHPD so there would be one report card.

Patient Data Disclosure to Hospitals: OSHPD has been very concerned about patient level data to ensure that the data cannot be used to identify an individual. In the past OSHPD disseminated multiple versions of the public data set. Now, only one version is given out to eliminate the possibility of linking multiple versions and have more data than otherwise would be disclosed. Because of small cell sizes, there was some masking of certain data elements, while preserving zip code level information. As a result, the amount of public data that became available was not as useful to hospitals and counties. Under California State law, counties and hospitals were not permitted to be recipients of confidential data and the Information Practices Act did not list them as eligible receivers of confidential data. AB 2876 was enacted to give OSHPD authority to release confidential data to hospitals, county health departments and selected federal agencies. The controls settled upon using the limited data set provisions of HIPAA.

OSHPD is attempting to create some standard packages of data that could be disclosed to hospitals under an agreement which would fulfill all the needs for community resource planning, quality of care issues, marketing issues, etc., to assure the protection of privacy.

Mr. Morris had an article from the LA Times entitled, “HMOs in Unstable Condition, Members Bolt to Other Plans,” and asked if OSHPD had a definition of the different forms of delivery of healthcare such as an HMO with a Kaiser-type structure, an HMO with a Pacific Care-type structure, other HMOs, and PPO. Dr. Royer said he could prepare a summary of definitions, and also suggested inviting a person from the Department of Managed Healthcare to speak on this issue. This topic will be an agenda item at the next meeting.

FDD Logbook Project: The Facilities Development Division Logbook is the system used for tracking the review of construction projects to know where a hospital is in the process, inspector of record, fees, etc., tools used to manage the Division’s workload. A feasibility study has been approved, and staff is bringing in consultants to help rebuild the system. Hopefully, this will include some wireless connectivity to enable a field inspector at a construction site to connect without a landline.

Enterprise Geographic Information System (EGIS): Later this month, the third phase of the project will be unfolded. Users of the OSHPD website should be able to query the database. A consultant will be brought in to attach the MIRCal system, the patient level data, to the EGIS system. By drawing a circle around a particular area, one can obtain summary information about a hospital’s financial, utilization, and patient care. In time, all of the data that are collected (financial, utilization, patient discharge and encounter data) will be rolled into the system.

The utilization data collection was automated a couple of years ago through the Automated Licensing Information and Report Tracking System (ALIRTS system). This is state of the art, using Microsoft for building web-based applications. The system is working very well, and staff is working on better compliance from some of the reporting facilities. A facility can log on, submit data, and make corrections through the edit checks. Once the data are accepted, the utilization data are immediately available on the web.

The quarterly reporting system, put on the Internet in 2000, is working well, but will probably be changed to update it to newer technology. The system can be queried for summary statistics.

Rewrite of Annual Financial Disclosure Reports: The annual financial disclosure reports for hospitals and long-term care is written in COBOL, one of the oldest programming languages. COBOL is still widely used, but it is getting more difficult to find COBOL programmers. OSHPD’s two COBOL programmers recently retired, but returned as retired annuitants. Dr. Carlisle said there was an article in the LA Times that cited the imminent

retirement of COBOL programmers across the country and the issues it was creating for lots of operations. This is actually a significant public policy issue.

Mr. Kassis said the financial system does not have a lot of functionality built into it like the new systems will have, but staff should be able to keep it together for a few more years as a new system is built. A consultant is being brought in to assist in writing the feasibility study report, which is a government requirement before approval can be given for information technology projects.

As OSHPD moves to more online systems, it forces the use of national standards. Vendors providing the operating software tend to be more consistent with the standards, and existing software can be used to extract the needed data. OSHPD works with clinics and vendors, using national standards, to make sure that the data collected in the practice software produces the same data needed for the online reports.

When facilities are late in submitting reports, they are fined for late submission. Facilities may have trouble with their information systems, a key person in the organization becomes ill, retires or quits, or the facility may have used up all the extension days and the deadline is near.

Status of Data Fund Fee Regulations: The Agency needs to review the special fee regulations setting the fee to .034%, which is below the maximum allowable of .035%, again before sending them to the Department of Finance and Office of Administrative Law for filing. The public comment period and issuing the notice to all facilities still needs to take place.

Status of Chargemaster Reporting: The chargemaster regulations will take effect on April 22. A notice has been sent to all facilities informing them that the rule-making regulation has been approved. Beginning July 1, 2005, the hospitals will need to submit their chargemasters, using the prices as of June 1. The chargemasters are to be submitted by e-mail or on CD, with the file format limited to Microsoft Excel, or common separated value file (CSV file).

Facilities were required to make the chargemasters available on location or to post them on their website, effective July 1, 2004. Submission to OSHPD takes effect this year.

Status of MIRCal Emergency Department and Ambulatory Surgery Data Reporting: Since 1996, the Commission and OSHPD have worked toward collecting inpatient data online making it more timely, and collecting emergency department and ambulatory surgery data. The last half of 2004 data should be available very soon. There are only about 20 hospitals that have not completed their submission of data. There is one penalty from a closed hospital, very troubled financially, which has now submitted the data.

Voluntary submission of emergency department and ambulatory surgery data began for the last quarter of 2004 data for testing. The testing period will end on April 11. The voluntary period went very well and staff is pleased with the lessons learned from that effort. The first mandatory reporting period for emergency department and ambulatory surgery begins April 11. The correct format is important so that OSHPD can check for viruses, and be assured of inclusion of all the required data. The hardest thing was for a facility to get the data into the right file format, with much education and outreach to deal with that issue. Vendors have been slow in updating their clients, and OSHPD has had teleconferences and face-to-face meetings to detail the requirements. OSHPD is now in the acceptance-testing mode and should have full acceptance by the end of April and then will be in the maintenance mode.

Tracking freestanding ambulatory surgery clinics has been an issue because of rapidly changing license status. About 470 hospitals are giving inpatient data successfully, with about 343 having emergency departments and 423 having ambulatory surgery clinics. There are about 451 freestanding ambulatory surgery clinics.

One of the hurdles OSHPD has had to overcome is justifying to the facilities the reason for collection of data from freestanding ambulatory surgery centers from a public health point of view and who will benefit from collection of the data.

Computer-based training was created and has been approved for continuing education by the California Board of Registered Nurses. Additional educational training can now be done by OSHPD as an approved provider. The computer-based training is free. Staff has communicated by posting on the web which is linked with some of the key associations, as well as letters, seminars, teleconferencing, and attending conferences and conventions. Staff also visited nine ambulatory surgery centers, at the suggestion of California Ambulatory Surgery Association (CASA). Key security authorization clearance is needed for about two-dozen clinics and it was suggested that CASA might be able to help with that.

Proposed Data Validation Study: OSHPD is concerned with the validation of coding of diagnosis for emergency data reports and would like to conduct a validation of the data, depending upon funding. By validating certain data elements, researchers and federal agencies can be assured of the quality of the coding of data elements for their use. It will also help OSHPD make the collection better. Staff has had conversations with the California Healthcare Foundation about securing additional funding for the validation study. It is costing approximately $15,000 per hospital to do an audit of their Coronary Artery Bypass Graph (CABG) program, which is not all the data that are submitted.

Dr. Weil noted that by adding emergency room and outpatient surgery center data, OSHPD would be collecting 15 million pieces of information, up from the previous 3.7 million records.

Healthcare Quality and Analysis Division Update: Joseph Parker, PhD --

Final Voluntary Coronary Artery Bypass Graph (CABG) Outcomes Report: The last voluntary CABG program report, a risk-adjusted mortality report for 79 hospitals through the years 1999-2002, will soon be released. This has been a joint voluntary effort between OSHPD and the Pacific Business Group on Health, the nation's largest coalition of big healthcare purchases, will soon be released. The mandatory program was enacted by the Legislature, causing a delay of more than one year to release the voluntary report, as there were not enough resources to deal with both the voluntary and mandatory effort.

First Mandatory CABG Outcomes Report: The Clinical Advisory Panel for the mandatory program will meet in a couple of weeks to look at the risk model and some preliminary results from the report. There are about 120 hospitals in California that perform heart bypass surgeries. The decisions made by the Panel will shape the timeline for the mandatory program report. Staff has been planning for a new online reporting system for CABG surgery data, and funding for a feasibility study report has just been obtained.

Clinical Data Outcomes Reports: The final ICU outcome report will not name hospitals. OSHPD was not able to recruit enough hospitals for the data collection to go public with the report and did not want to penalize the hospitals that voluntarily participated. It will be a study with some recommendations for moving forward. Most of the patients dying in a hospital die in an ICU. Only mortality and other complications are looked at.

Administrative Data Outcomes Reports: Steve Lubeck, who heads up the Administrative Data Outcomes Reporting Unit, will soon retire, which could slow these reports down. Last week, a clinical panel approved a new AMI heart attack model, and a new report on AMI outcomes could be released later this year.

The Maternal Outcomes Report, which is a contracted report currently being done by Dr. Patrick Romano at UCD is being completed. Hopefully, early next year there will be a report on risk-adjusted admissions for childbirth, which looks at the outcomes of second and third degree perineal lacerations. Part of the product is to develop a brochure that is client-oriented.

A second Community-Acquired Pneumonia Report will probably be released next year.

Preventable Hospitalizations Over Time Report: The Division is working with the Healthcare Resources Center to develop new products, one of which is a report on preventable hospitalizations over time. The time period is 1997 through 2003, statewide and countywide, adjusted for sex and age of the populations. This report is directed toward the counties and public health officers to understand admissions for 15 potentially preventable hospitalizations, ranging from pediatric conditions such as asthma and gastroenteritis to leg amputations from diabetes, and congestive heart failure. OSHPD will try to obtain feedback from the county public health officers to be sure this is useful information. The report has not yet had the Director's Office review.

An interesting result from the study regarding pediatric conditions is that there has been an approximate 25 percent decline in potentially preventable hospitalizations for those conditions from 1997 through 2003, credited to the efforts to insure all children in California. There was about a 10 to 15 percent increase in admissions for three diabetes-related conditions.

HMOs have had a long history of disease management programs for such things as asthma, diabetes, hypertension, and congestive heart failure. One of the interesting things is to see whether counties that have HMO-managed based plans for the Medicaid population is doing better than other counties in some of these areas. Until now, there was no one organization that had access to all of the State's data.

Addition of New Data Elements: Dr. Andy Bindman at UCSF, under contract, has conducted a series of focus groups composed of various stakeholders, to resolve the selection of the 15 new discharge data elements to be collected over a period of five years. He will be presenting some of these preliminary findings on April 26.

Healthcare Information Resource Center: Jonathan Teague, Manager

Mr. Teague gave a brief demonstration of the website and the publications available on the website.

The purpose of the redesign of the website was to be more user-friendly in accessing data. This redesign improves the layout and the organization, making it more logical.
Mr. Teague mentioned that the computer-based training mentioned above will be featured at the upcoming Government Technologies Conference, as an example of what can be done for training people, using information technology resources to do complicated tasks.

Mr. Kassis recently attended a meeting of state and county information officials, where OSHPD was awarded for its MIRCal and EGIS systems.

Dr. Royer said he wanted to publicly thank Mr. Teague for providing him with information on C-Section rates, which helped to put together a statewide initiative. Dr. Royer said they will be working toward an appropriate C-Section rate, as well as high risk maternity to keep the pregnancy as long as possible.

Retirement of Executive Secretary (Director): Jacquelyn Paige who has been the Executive Secretary (Director) of the Commission since late 1990 will soon be retiring. Ms. Paige has accumulated 20 years of service in State Government. She began her career with the San Joaquin County Department of Mental Health before moving to the California State Department of Mental Health, and the Health and Human Services Agency.

Next Meeting: The next Commission meeting will be held on June 6 in Southern California.

Adjournment: The meeting adjourned at 2:30 p.m.